Plan Date:

Residential Support Plan

Section I: Personal Information

Name: **Preferred Name:**

Social Security Number: **Medicaid number:**
Medicare number:

Address:

Phone Number: **DOB:** **Gender: Male ☐ Female ☐**

Name of Primary Contact: **Address:** **Phone:**

Name of Emergency Contact: **Address:**
Phone:

Section II: Critical Information

Allergy: **Reaction:** **Response:**

Medication precautions:

Behavioral Alerts (pica, self-abusive behavior, etc):

Living Will, Advance Directives: ☐ yes ☐ no Location:

Other:

Section III: Personal Focus

What do people like and admire about this person?

What is most important to this person?

What are this person's life goals?

How is this person connected to the community?

Describe relationships that are important to the person: (family, friends, etc):

What is currently working well that needs to be continued or enhanced? (Include progress on current training objectives.)

What needs to change? (Include any changes needed in current training objectives.).

Section IV: Safety/Supervision

Does this person need assistance to adjust water temperature? ☐ Yes ☐ No Comments:

Does this person need assistance to evacuate when a fire or smoke alarm sounds? ☐ Yes ☐ No Comments:

Does this person need assistance to remain safe around household chemicals? ☐ Yes ☐ No Comments:

Are there any other important or serious safety issues?

Describe in explicit behavioral terms how staff are to supervise the person during the times below. (Include frequency of supervision checks, method, documentation and frequency of documentation.)

Awake: (specific to location if needed ex. At home, in the community, etc)
Sleeping:
Bathing:
Dining:

Does this person remain at home without staff support? ☐ No ☐ Yes How long?

Does this person go away from home without staff support f☐ No ☐ Yes How Long?

Is HRC of supervision needed? ☐ Yes Date of last review:
☐ No Explain:

Comments:

Section V: Rights

Does person have a legal guardian? Yes ☐ No ☐

Name and contact information:

Comments:

Does person understand their human, constitutional and civil rights? No: ☐ (If no, training must be implemented) Yes: ☐ Comments:

If needed, who will provide assistance in understanding and exercising rights?

Are any rights currently restricted? Yes ☐ No ☐ (If yes explain)

Are restricted rights reviewed/approved by Human Rights Committee? ☐ Yes ☐ No Date of last review:

Section VI: Medical

Health Condition/ Diagnosis	Medication	Dosage	Frequency	Given By	Prescribing Physician
				☐ staff ☐ Self	
				☐ staff ☐ Self	
				☐ staff ☐ Self	
				☐ staff ☐ Self	
				☐ staff ☐ Self	
				☐ staff ☐ Self	
				☐ staff ☐ Self	

Date of last physical exam:

Name of Primary Doctor: **Address:** **Phone:**

Pharmacist: **Address:** **Phone:**

Hospital: **Address:** **Phone:**

Hospitalizations or major illness during past year:

PPD:

Dentist: **Date of Last dental exam:**

Eye care professional: **Address:** **Phone:**

Date of last vision exam:

Other Health Professionals: (OT, pt., etc):

Diet: ☐ **Regular** ☐ **Other** **Describe:**

Foods allergies:

Foods he/she does not like:

Adaptive dining devices:

Dietitian: **Phone:**

Additional Comments Related to Medical:

Section VII: Adaptive Skills

Communication: ☐ **verbal** ☐ **uses signs** ☐ **gestures**

Hearing: ☐ **yes** ☐ **no** **Adaptive Devices/schedule of use:**

Walk: ☐ **yes** ☐ **no** **Adaptive device/schedule of use:**

Section VIII: Behavior

Does person display dangerous behavior? ☐ **Yes** ☐ **No**

If yes, describe:

Behavior Support Plan/Guidelines: ☐ **yes** ☐ **no** **(If yes, attach)**

Is BSP restrictive? ☐ **Yes** ☐ **No**

Date of consent:

If plan is restrictive, date of most recent Human Rights review and approval:

Section IX: Skills Training

Date and summary of most recent Comprehensive functional assessment: (Include name of tool used and summary of results:

	Goal	Training Objective	Life Goal to Which It Relates
1			
		Person Responsible Target Date	
2			
		Person Responsible Target Date	
3			
		Person Responsible Target Date	
4			
		Person Responsible Target Date	
5			
		Person Responsible Target Date	

Comments: (If needs have been identified that you are not training on, explain.)

Name:
Date:

Signature Sheet for Plan Meeting

Name	Title